APPENDIX B: HOSPITAL COMMENT LETTERS

The law that created the California Administrative Data Program specified that hospitals and their medical staff be given 60 days to review their results before the report is released to the public. Hospitals and their chiefs of staff are encouraged, but not required, to submit written comments.

Issues of Concern in Hospital Comment Letters

For the 2002-2004 CAP Report, a total of ten letters were received. They addressed the following topics:

1. Improved quality assessment and patient services

Four stated that the report prompted them to initiate new programs to improve quality of care and outcomes for CAP patients. These included quality assurance activities such as review of pneumonia order sets, protocols for use of antibiotics, and appointment of a quality assurance team. They also described new patient services that were being implemented, including a public education program concerning pneumonia and increased access to influenza and pneumococcal immunizations.

At least two of the hospitals are participating in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Core Measure for Pneumonia.

> Response: The Office is very encouraged that these hospitals are using this analysis to take meaningful steps to improve care for pneumonia patients.

2. Concerns about data quality

One hospital, upon reviewing the patient data, found that DNR status had been under-reported in their administrative abstracts. Another expressed concern that the report was based on “old” data.

Three letters stated that after reviewing their CAP patient data they found that patient “source” had been miscoded by their own medical records offices; patients who had transferred to the hospital from board and care or nursing “homes” had been erroneously reported as admissions from “home.” Thus, some high risk patients were included in the analysis that, with correct coding, would not have been. This issue was also reported in the previous CAP report.

> Response: Findings of the previous CAP report were provided to hospitals September 2003, for the required 60-day review period prior to release of the public report. OSHPD sent each facility its own statistical results and a dataset containing all the CAP patient information utilized in the report.
>
> Based on these materials, hospitals that became aware of coding problems in the in-patient discharge data submissions from their facility had an opportunity

to amend any of the 2003 data they had already submitted and could also have remedied any coding problems before submitting data for the remainder of that year. Further, they could have put improved coding practices in place for all data submissions for 2004 and for subsequent years.

Correct coding of "source of admission" is explained for reporting facilities in the *Patient Discharge Data Reporting Manual*. An update of the manual was mailed to each hospital by OSHPD in August 1994, which explained how to code "source of admission." These instructions are still in effect at the time of this writing. The Manual states that source of admission is coded as "Residential Care Facility" for "A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare." It further clarifies that "The facilities are referred to by a variety of terms (e.g., board and care, residential care facilities for the elderly)."

In contrast, source of admission should be coded as "Home" for "A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home." It includes patients admitted from "…a half-way house, group home, foster care, women's shelter, Alcoholism or Drug Abuse Recovery or Treatment Facility as licensed by the Department of Alcoholism and Drug Programs, or A mother who delivers at home and the baby born at home."

Facilities that identify shortcomings in their data abstracts may benefit from review of their record abstraction process and introduce changes in staff training or instructions to prevent future errors.

3. Concerns about the model

There was no overall objection to the use of the multivariable risk-adjustment model. Two hospitals stated that use of "all-cause" mortality, instead of just counting deaths directly attributable to pneumonia, was inappropriate.

Response: All hospitals, and the statewide mortality benchmark, are based on the same "all cause mortality" measure. It is possible that some hospitals have a higher proportion of patients at risk for post-discharge trauma or for death from their other illnesses (co-morbidities). In these facilities, mortality may be reduced by improved discharge planning.

Another hospital recommended that the model be risk-adjusted using the All Patient Refined-Diagnostic Related Groups (APR-DRG) system, developed by 3M and used by the Agency for Healthcare Research and Quality (AHRQ) and others for healthcare performance measurement.

Response: The Technical Advisory Committee for OSHPD recommended use of the risk-adjustment methodology reported here. This was based on extensive clinical and statistical analysis of the data and on the clinical management issues related to CAP. The APR-DRG system is not appropriate as a risk-adjustment system for

public reporting because it inappropriately credits hospitals with more complications as having sicker patients. The current report uses the condition present at admission indicator, available only in California and New York states, to separate pre-existing illnesses included in the risk model from post-admission complications.

Finally, one hospital observed that the model omits important risk factors for death that remain outside the control of the hospital, such as patient exposure to pathogens and noncompliance with medical instructions.

Response: This is an important consideration and affects the results for all the hospitals included in this report. The mortality outcomes can only be risk-adjusted for factors that can be measured and are currently available in the patient discharge abstract. As noted above, several of the responding hospitals appear to be addressing this issue by introducing new patient education and immunization programs.

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Century City
Doctors Hospital
Health Information Management

June 30, 2006

Joseph Parker, Ph.D.
Director, Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Subject: California Hospital Outcomes Report on Community- Acquired Pneumonia, 2002-2004

Dear Mr. Joseph Parker,

The purpose of this letter is to submit a comment on the OSHPD preliminary report on community acquired pneumonia (CAP) from 2002-2004. We would like to clarify that was purchased by the Salus Group and opened on October 14, 2005. The published results are those from **Century City Hospital** a Tenet facilty. We would like to make sure that the public is aware of this distinction. Please do not use the name **Century City Doctors Hospital** in your published report. Thank you for your help in this matter.

Sincerely,

Joel M. Bergenfeld
CEO, Century City Doctors Hospital

A Member of the Salus Surgical Group

2070 Century Park East, Los Angeles, CA 90067 t: 310.772.4000 fax: 310.220.6530 www.ccdoctorshospital.com

Community Hospital of the Monterey Peninsula®
Innovative healthcare with a human touch

July 6, 2006

Joseph Parker, PhD, Director
Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

Community Hospital of the Monterey Peninsula strives to be the healthcare organization in our region most concerned for those we serve, most chosen for the quality and value of our services, and most respected for the integrity, competency, and commitment of our employees, medical staff, and volunteers. We thank you for the opportunity to review the outcomes report on community-acquired pneumonia.

We are pleased with our overall results in this study yet we are confident that we will do even better in the future. The physicians and employees of the organization set aggressive targets for clinical improvements, and we are committed to achieving those targets year after year. We have consistently demonstrated appropriate use of antibiotics in target groups of pneumonia patients and our immunization rates are in the upper ten percent of all hospitals. Our teams of physicians, nurses, pharmacists, and other caregivers continue working together to improve the care we provide for patients with community-acquired pneumonia.

We strongly support the public's right to receive information that will assist in making informed decisions about healthcare. We also believe it is important for healthcare consumers to understand the limitations and complexity of this data and encourage OSHPD in its effort to make the information as clear and transparent as is possible. At Community Hospital of the Monterey Peninsula we know that providing quality care requires vigilance and continuous effort. We are never satisfied and always strive to do the best for our community.

Sincerely,

Steven Packer, M. D.
President/CEO

Post Office Box HH, Monterey, California 93942-1085 ▪ (831) 624-5311

C. Barry Dykes
Chief Executive Officer
Tenet California

Desert Regional Medical Center
1150 N. Indian Canyon Dr.
Palm Springs, CA 92262

August 14, 2006

Joseph Parker, Ph.D., Dir. Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker:

In response to the OSHPD report on Community Acquired Pneumonia, Desert Regional Medical Center undertook an extensive retrospective review of the 53 mortalities identified. Upon review, several issues emerged which may have significantly contributed to the overall mortality rates.

Desert Regional Medical Center is fortunate to have an inpatient hospice unit. Nine of the 53 cases were either transferred to the hospice unit or admitted directly to the unit for comfort care only. The risk adjustment model does not take hospice care into consideration. We believe that this unique service truly sets our facility apart in terms of the patient population and type of services provided.

A second issue identified was that 12 of the 53 patients are listed in the OSHPD data set as being a full code whereas they actually were Do Not Resuscitate patients within 24 hours of admission.

In addition, two of the 53 patients reviewed were admitted from a nursing home, and therefore should have been excluded from the data set. Another 2 of the 53 patients reviewed left AMA.

While this review allowed us to examine the care that we provided in the past, it is also important to note that we actively participate in the pneumonia core measure set, and have so since 2001. Our data indicates that we are currently 93% compliant with pneumonia core measure guidelines for calendar year 2006.

In summary, we believe that our inpatient hospice unit as well has an inaccurate notation of the code status of our patients contributed to the reported mortality rates for our Community Acquired Pneumonia patients. Desert Regional Medical Center is committed to providing high quality patient care for the patients in the Palm Springs community.

Sincerely,

C. Barry Dykes
Chief Executive Officer

JOHN MUIR HEALTH

1400 Treat Boulevard
Walnut Creek, CA 94597-2142

A not-for-profit organization

August 10, 2006

Joseph Parker, PhD
Director, Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, California 95814

Dear Dr. Parker,

Thank you for the opportunity to review and comment on the Community-Acquired Pneumonia (CAP) data provided for years 2002-2004. We have carefully reviewed the results and are pleased to find that our outcomes compare favorably with participating hospitals. While the care we provide to our patients is based on best practices, the use of both external and internal benchmarking and performance improvement strategies, allows us a continuous opportunity to evaluate our efforts to provide the best possible care to our patients. Our participation in many national initiatives assists our organization in maintaining a cutting edge approach to quality patient care.

Thank you again for the opportunity to gain perspective on our performance as it related to the larger healthcare community and to participate in this important aspect of patient care.

Sincerely,

Kenneth Meehan
Executive Vice President, Operations

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.

August 14, 2006

Joseph Parker, Ph.D.
Health Care Quality and Analysis Division
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear. Dr. Parker:

We have reviewed data from the draft of the Community Acquired Pneumonia Outcomes Report. Community Acquired Pneumonia is a serious health problem and it accounts for many deaths among Californians. Kaiser Permanente is committed to actions to improve the care of patients who enter the hospital with this diagnosis. We support wholeheartedly the efforts of the State to provide information that would permit us to identify hospitals where care is suboptimal, in order to address quality issues, and to identify those hospitals that perform above average as a means of identifying best practices. We are concerned; however, that the CAP Outcomes Report may mislead the public about the quality of care provided because of problems with the coding of source of admission.

We have identified that 25-30% of patients admitted to our hospitals from Board and Care facilities were inadvertently given codes that identified them as being admitted from home. Patients admitted with pneumonia from Board and Care facilities are often very high risk for complications and death. The inclusion of these people as cases of community acquired pneumonia along with the people truly admitted from home with pneumonia causes a substantial bias in mortality outcomes for this diagnosis. The risk-adjustment procedure used by the State would not overcome the upward bias in mortality outcomes for community-acquired pneumonia.

We believe strongly that the Community Acquired Pneumonia Outcomes Report does not reflect the reality of hospital quality care, nor the true risk of death following community acquired pneumonia because of inaccuracies in the data on source of admission. The problem with the data could be corrected for our patients and those at other hospitals by requiring verification of admission source for all deaths among patients now classified as community acquired pneumonia. We are currently expending resources to assure that this is done for patients in our hospitals. Unfortunately, this data correction process is not currently permitted to update calculations for the OSHPD report.

Kaiser Permanente is eager to work with OSHPD to assure that the CHOP project is successful and drives quality improvement, and we will continue working to assure that the documentation and coding in our medical records accurately reflects the excellent care provided to our members.

Sincerely,

John Brookey, M.D.
Assistant Medical Director
Quality and Risk Management
Southern California Permanente Medical Group

Patti Harvey
Director, Patient Safety and Risk Management
Kaiser Foundation Hospitals, Southern California

Walnut Center
Pasadena, CA 91188

NORTHBAY™
HEALTHCARE SYSTEM

23 August 2006

Joseph Parker, Ph.D.
Director, Healthcare Outcomes Center
Healthcare Information Division
Office of Statewide Health Planning and Development
818 K Street, Room 100
Sacramento, CA 95814

Dear Dr. Parker:

The NorthBay Healthcare Group (NorthBay Medical Center and VacaValley Hospital) appreciates the opportunity to review and submit a letter responding to the Community Acquired Pneumonia Report Mortality data for 2002-2004. We are very pleased to see that our performance improvement efforts over the last 2 ½ years are reflected in these numbers.

With the receipt of the 1999-2001 data we performed an in-depth review of our pneumonia cases and established a hospital wide Pneumonia Performance Improvement Team. Since that time we have been monitoring our data and performing in-depth analysis to determine specifically where our process improvement efforts would best be focused. We have implemented many new initiatives and revised several processes. We provide detailed data analysis and focused staff education to all personal that participate in the care of our Pneumonia patients.

We are very please that the 2002-2004 Community Acquired Pneumonia data reflects a marked improvement as a result of our ongoing efforts. Continued improvement remains a focus of our Performance Improvement Team.

Sincerely,

Deborah Sugiyama
President
NorthBay Healthcare Group

Donald M. Denmark MD, FAAFP, FCFP
Vice President Medical Affairs,
NorthBay Healthcare Group,

Compassionate care, advanced medicine, close to home.

1200 B. Gale Wilson Blvd.
Fairfield, CA 94533-3587
Ph 707.429.3600

Oak Valley Hospital District
A Division of Oak Valley Hospital District
An Affiliate of Catholic Healthcare West

August 14, 2006

Joseph Parker, Ph.D.
Office of Statewide Health Planning & Development
Healthcare Quality and Analysis Division
818 K Street, Room 200
Sacramento, CA 95814

RE: California Outcomes Report on Community-Acquired Pneumonia, 1999-2001

Dear Mr. Parker,

Oak Valley Hospital District (OVHD) is a 35 acute-bed rural facility located in the San Joaquin Valley. As a rural facility, the number of cases seen is limited. Despite the relative low incidence of patients with a diagnosis of pneumonia, Oak Valley Hospital District is committed to ongoing clinical quality improvement not only for patients with pneumonia, but all patients.

We support the analytic approach undertaken by the Office of Statewide Health Planning and Development with this project. The California Hospital Outcomes Project on Community-Acquired Pneumonia provides a unique opportunity to evaluate our performance in relationship to hospitals across the state. While we applaud the efforts to obtain information of this nature from hospitals, one of the limitations is that this data reflects patient care rendered from 2002-2004.

Over the last several years, OVHD has moved to a focus of continuous quality improvement. Data is now assessed on a continual basis and strategies are implemented and modified continuously to improve processes and outcomes. During the data collection period, Oak Valley Hospital focused on Community-Acquired Pneumonia as one of the core measures reported to the Joint Commission on Hospital Accreditation (JCAHO). Overall, OVHD realized a risk-adjusted observed death slightly higher than expected. Since the time of this study continuous improvement activities have been initiated to decrease the death rate and optimize patient outcomes.

An additional concern with release of this information to the lay public relates to the implication that patient outcomes, such as mortality, are solely due to the interventions initiated by the treating facility, when in fact the patient's own

350 South Oak Avenue • Oakdale, CA 95361 • Phone: (209) 848-3011

health maintenance and willingness to comply with the treatment regime is key to long term survival. Despite these few identified concerns, we feel that the information presented to the public from this project will be favorable. Our participation in the California Hospital Outcomes Report on Community-Acquired Pneumonia demonstrates our commitment to the residents of our community to provide optimum care.

Sincerely,

John Friel
Chief Executive Officer

Placentia Linda
Hospital
Tenet HealthSystem

1301 Rose Drive
Placentia, California 92870
Tel 714.993.2000

August 25, 2006

Joseph Parker, Ph.D
Director of Healthcare Outcomes Center
818 K Street, Room 200
Sacramento, CA 95814

Dear Mr. Parker:

RE: California Hospital Outcomes Report On Community-Acquired Pneumonia, 2002 – 2004

Placentia-Linda Hospital received and reviewed the letter, addressing Community Acquired Pneumonia Mortality - Outcome Data, you sent to us on June 23, 2006. Our Hospital Administrative Team and members of our Medical Staff reviewed the risk-adjusted statistics enclosed, and all agreed to offer the Office of Statewide Health Planning and Development some clarification and explanations for our "above State Average Mortality Rate" related to the years 2002 through 2004. When we inquired about time limits for our "comment letter", we were informed by Niya Fong, that we had until August 30, 2006 to respond to your findings. Your original letter states that the deadline for response was August 15, 2006, but Ms. Fong informed me on July 7, 2006, that we had a two (2) week extension due to "system failure".

As I am sure you are aware, Placentia Linda Hospital participates in the JCAHO CORE Measure & other Regulatory Agency Reporting, and Community Acquired Pneumonia is incorporated in those studies. Together with our Medical Staff, we have been steadily developing methodology to ensure that all of our patients receive the highest quality standard possible. Our hospital is poised for continued growth and service to the community and surrounding areas we serve. The population in North Orange County is gradually evolving to increases in Residential Care and Assisted Living Services. Additionally, our neighbor hospital, Brea Community Hospital, recently closed its doors, which increased the elderly population admissions to our hospital.

We noted, that of the three hundred and nineteen (319) Community Acquired Pneumonia Diagnoses, that twelve (12) cases had died at discharge, and seven (7) had died within 30 days of discharge, to total nineteen (19). The average age of these patients was 78 years. The average length of stay was 2.6 days. Of the nineteen cases, twelve were DNR Status on admission. When you consider the population age we are currently serving, we feel that your reference on page 4 (Clinical Risk Factor (s) not included in the Model) has a tremendous bearing on our numbers. **We have attached our Comment Letter to be included in the final report.**

We thank you for your Report and allowing our hospital the opportunity to respond and clarify the above State Average Mortalities we are currently experiencing. Our hospital is striving to decrease our associated mortality numbers, by initiating methodology/protocols and following all the regulatory clinical mandates that will improve outcomes for the population we serve. If you have any questions you may reach me at (714) 524-4801, or speak with Erlene Tarr, our Quality Manager, at (714) 524-4841.

Sincerely,

Kent Clayton

Kent Clayton, Chief Executive Officer

Cc: Paul Weinstein, MD, Quality/Utilization Physician Advisor
Erlene Tarr, MN, RN – Director of Clinical Quality Improvement
Patricia Scott, RN – Director of Nursing

TENET

Placentia Linda
Hospital
Tenet HealthSystem

1301 Rose Drive
Placentia, California 92870
Tel 714.993.2000

Comment Summary Letter of Clarification on Clinical Risk Factors of Population contributing to Community Acquired Pneumonia Mortalities.

August 25, 2006

Placentia Linda Hospital would like to offer a clarification on the Hospital's reported Risk Adjusted Pneumonia 30 - Day Mortality Rates for 2002 through 2004. In North Orange County there has been a significant growth in Residential Care and Assisted Living Services, thus increasing the population of those elderly residents, who are at risk for Community Acquired Pneumonia. Our Hospital is one of three hospitals that serve this area, and we receive many elderly patients in our Emergency Department, with an average age of 78 years.

In order to serve our population with protective quality care, we have initiated and implemented an education program, which provides the public with information and access to Influenza and Pneumococcal Vaccine. Our caring nursing and medical staff have been trained to provide detailed information on Pneumonia Prevention, and to assist our community in obtaining the necessary preventive medicine, to insure Pneumonia Prevention. Going forward, we are confident, that this will decrease the Community Acquired Pneumonia rates for our population.

TENET

PRESBYTERIAN INTERCOMMUNITY HOSPITAL

PRESBYTERIAN HEALTH

12401 Washington Boulevard
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Hearing Impaired TDD (562) 696-9267

August 8, 2006

Joseph Parker, Ph.D.
Director, Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Dr. Parker,

Thank you for the opportunity to review and respond to the California Hospital Outcomes Report on Community Acquired Pneumonia (CAP). Presbyterian Intercommunity Hospital is committed to continuously seeking opportunities to further improve and validate the quality of care it provides.

We have carefully reviewed our hospital's results in OSHPD's Report on CAP mortality. We are pleased to see that our mortality rates are better than the state average excluding DNR as a risk factor. We do note however, our opportunity for improvement in the model including DNR as a risk factor. In this light, Presbyterian is participating in the Joint Commission on Accreditation of Healthcare Organization's Core Measure program which identifies Community Acquired Pneumonia guidelines. In doing so, we will be able to continually monitor several process and outcome indicators associated with CAP and benchmark our performance. In collaboration with the medical staff, we have recently revised our CAP order sets. The revisions are based on best practices and will standardize the care and treatment of these patients and ultimately improve outcomes such as 30-day mortality rates.

One final comment regarding the methodology utilized in this study. We recognize that death within 30 days of admission is an important data point: however, we have significant concerns that a death from any cause or location is linked to the initial hospitalization. Some patient deaths occurring after discharge may not relate to the patient's pneumonia or to the quality of care during the patient's hospitalization.

Again, thank you for the opportunity to review and comment on this CAP report. Presbyterian Intercommunity Hospital remains committed to providing high quality healthcare to the communities we serve.

Sincerely,

J.R. Hamilton MD

J. R. Hamilton, MD
Vice President, Medical Affairs

Redlands Community Hospital

350 Terracina Blvd.
P.O. Box 3391
Redlands, CA 92373-0742
909-335-5500
Fax 909-335-6497

August 15, 2006

Joseph Parker, Ph.D., Director, Healthcare Outcomes Center
Office of Statewide Health Planning and Development
818 K Street, Room 200
Sacramento, CA 95814

Dear Mr. Parker,

This is in response to OSHPD's Draft Community Acquired Pneumonia (CAP) report, which we recently received. Thank you for providing us a copy of the data utilized by OSHPD for this study. After careful review of Redlands Community Hospital (RCH) data, please accept our response based on our analysis of the data for CAP patients identified during years 2002-2004.

RCH Data

This second CAP study appears to be constructed very similar to the first CAP study submitted for publication by OSHPD in 2003. The details of how this study was conducted were not provided to hospitals as was for the first OSHPD CAP study. Both CAP studies included only those patients whose admission source was "home". During our review of the 1st CAP study data, our analysis revealed some data abstracting errors as related to the "admission source". At that time we had requested, but were denied, the opportunity to resubmit the data as the error would have excluded half of the patients included in the study. Since the publication of the 1st CAP study, we have since made significant efforts to ensure accurate data abstraction. However, some of the data errors we had discovered in our 2002 data are still present in this 2nd CAP study since the deadlines for data submission had long passed. Thus we feel the results being represented of Redlands Community Hospital are not accurate and should not be published as such.

Since we assume the second CAP study will also be published, we reviewed the OSHPD report and analyzed our 2002-2004 data very closely. We analyzed our patient data, utilized in this study, with the widely accepted APR-DRG methodology for severity and risk adjustment. This method is utilized by hundreds of hospitals nation-wide as well as governmental agencies and commercial healthcare data entities, such as Solucient. APR-DRGs provide scores for both the severity of illness and risk of mortality on a patient level. Each CAP case was reviewed with findings as follows.

- CAP Patients who expired at RCH (2002-2004):
  - 92% had a severity of illness of either major or extreme. This would be the expected severity of illness for any inpatient death.
  - 89% had a risk of mortality of either major or extreme. Again, combine with the above severity of illness scores; this is to be expected for any inpatient death.

- CAP Patients who expired post discharge from RCH (2002-2004):
  - 77% had severity of illness of either major or extreme.
  - 54% had a risk of mortality of either major or extreme.

Post Hospitalization Care

Once determining the severity of illness and risk of mortality experienced by or CAP patient population, our next concern raised the question of the quality of healthcare provided by post discharge care providers. Since the majority of our CAP patients who did not expire in the hospital were discharged to skilled nursing facilities for post discharge care, how well do SNF's provide care to our discharged

patients? Clearly, a hospital cannot control the quality of care provided by SNFs; yet, hospitals could review report cards provided by Medicare and determine if some do provide better care than others and adjust practices accordingly.

Concerns re: Study Design

Another concern was raised regarding the design of this study. In this OSHPD CAP model, any death of a CAP patient is counted against that hospital as long as they expire within 30 days of being admitted to the hospital. The study does not consider what the death was due to. It does not consider whether or not the pneumonia led to the death, rather, only that the patient died. A patient could die of something totally unrelated, yet the death would be counted against the hospital.

Our analysis revealed that the CAP patients who expired either in the hospital or post discharge were generally extremely sick upon admission with multiple comorbidities and often diseases of multiple body systems. The APR-DRG system fully considers all contributing comorbid conditions as opposed to a few select conditions used by the OSHPD risk adjustment model.

If one considers a short stay patient with a length of stay of 3-5 days and is subsequently discharged to a skilled nursing facility, remains there for the next three weeks and subsequently dies, how can it be fair to count the death is against the hospital while never disclosing to the public that the patient(s) have received post discharge care by other healthcare providers? When publishing the results to a healthcare study intended for general public, it is important to disclose all the facts, not mislead the public with a couple of percentage numbers or misrepresent the quality of care provided the hospital.

Recommendation

We support OSHPD's desire to assist the public in making informed healthcare decisions. As all of us in the healthcare industry are aware, identifying and agreeing to definitions of quality and providing the data to measure and compare against these definitions can be difficult. However, utilizing industry recognized severity and risk adjustment methodologies would be one step forward towards standardizing quality of care measurements. We recommend that in the future OSHPD utilize severity and risk adjustment systems that have been developed by physicians and account for all clinical conditions of a patient, not just a few select conditions.

We further recommend OSHPD should not publish this second CAP study knowing that some raw data was erroneous during the first study and subsequently during the second study since hospitals could not resubmit corrected data. Contrary to OSHPD's intent, this report misrepresents hospitals and their medical staffs and does a disservice to the general public. Rather than assisting individuals in making more informed decisions about healthcare, this report is inaccurate, and not in keeping with the level of service and quality the public expects from its government officials.

Sincerely,

James R. Holmes
CEO / President

cc: OSHPD Director; HASC President